STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005068	A. BUILDING: _____ B. WING _____	03/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY HOSPITAL EAST	1500 N RITTER AVE INDIANAPOLIS, IN 46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for a State complaint survey. Intake Number IN00141224 Unsubstantiated; lack of sufficient evidence Survey Date: 3-4-14 Facility Number: 005068 Surveyor: Jack I. Cohen, MHA Medical Surveyor Community Hospital East was found in compliance with 410 IAC 15-1.5-2, Infection control and 15-1.5-8, Physical plant, maintenance and environmental services, Indiana Hospital Licensure Rules. QA: claughlin 04/02/14	S 000		